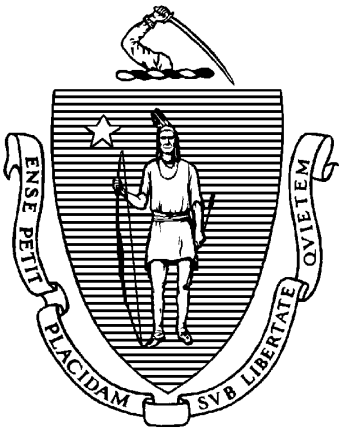

Mitt Romney
Governor

Julianne M. Bowler
Commissioner of Insurance

Kerry Healey
Lieutenant Governor

Consumer Information Guide: <u>Nongroup</u> Health Insurance Plans in Massachusetts

Who is Eligible? When Can I Enroll in a Plan?

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Disclaimer

The Division of Insurance does not sell, recommend, promote, nor endorse any insurance product, company, or agent. The information in this guide is being provided to assist consumers in making informed purchasing decisions. Every effort has been made to ensure the accuracy of this information; however, some of the information may be subject to correction. This guide will be updated periodically.

Please note that this guide applies only to policies available for sale in Massachusetts to individuals and families who are "eligible individuals" as defined by law.

Chapter 176M of the Massachusetts General Laws allows certain Massachusetts residents to purchase nongroup health care insurance or coverage from any carrier offering plans. Carriers offering this coverage cannot refuse any applicants based on their health but beginning with those applying on and after November 1, 2001, carriers may impose pre-existing condition exclusions or waiting periods. This publication is intended to

- explain your rights to purchase coverage under this law;
- tell you which companies offer nongroup health coverage;
- tell you how to contact health carriers for more information regarding nongroup health coverage; and
- tell you what you need to know if your coverage may end in the future.

Who is eligible?

You and your dependents are eligible for this coverage if:

- you are a Massachusetts resident; AND
- you are not enrolled in Medicare or Medicaid (MassHealth).

With changes that became effective November 1, 2001, self-employed persons are permitted to enroll in either a small group plan or a nongroup guaranteed issue plan.

When can I enroll in a plan?

There is a continuous open enrollment period so that your coverage will become effective within 30 days of submitting an application. Please do note, however, that if you purchase coverage after a break of more than 63 days, your plan may have up to a six-month pre-existing condition limitation or a waiting period.

Can I be denied coverage because of my medical history?

No. Participating health carriers cannot deny you or your dependents coverage unless you live outside their defined service area, you do not pay the plan premiums or you falsified information on your application or other plan documents, such as claim forms.

Carriers are, however, permitted to impose up to a six-month pre-existing condition limitation or a six-month waiting period (during which only emergency care is covered). Carriers that do impose a pre-existing condition limitation or waiting period are required to waive or reduce the period depending upon prior coverage that you may have had up to 63 days before completing an application. You may contact the health plans offered in the market regarding any such limitations and whether any will apply to your situation.

What is covered in the standard nongroup plans?

Carriers offering plans in the nongroup market must offer a plan with a standard set of benefits including emergency, hospital and physician services, preventive care, and prescription drugs administered on an outpatient basis as designed by the Nongroup Health Insurance Advisory Board. These required plans may include cost-sharing (such as deductibles and co-payments), but the amounts cannot be greater than those approved for the standard plans.

There are three types of standard nongroup plans offered in the market:

- **Medical plans**, without any restrictions on choices of medical providers. *This is a traditional health plan in which you may go to any licensed hospital, doctor, or provider for your treatment.* In the standard plan, you will be required to pay an annual deductible ($700 per member/$1,400 per family) and 20% of the cost of most covered services.

- **Preferred provider plans**, with incentives to go to preferred providers. *In these plans, you may go to any licensed hospital, doctor or provider, but you will pay a smaller share of the cost if you go to providers on the preferred list.* In the standard plan, you will be required to pay an annual deductible ($250 per member/$500 per family) and 10% of the cost of covered services from preferred providers and 30% of the cost of services from all other providers.
- **Managed care plans**, offered by HMOs with closed networks of providers. *Except in cases of emergency and specific situations, you must use providers within the HMO network in order to receive benefits.* In the standard plan, there are copayments ranging from $15 for each office visit to $500 for a hospital stay.

Are there any other options available?

Carriers are allowed to offer one plan in addition to the standard plan. This alternate plan must include all the same core benefits as the standard plan, but may have higher copayments or deductibles and may exclude prescription drug coverage. Although the alternate plans are listed on the Division's lists, you should contact the company for more information about available options.

What about the nongroup coverage I already have?

The coverage that you already have is guaranteed renewable; you may remain in your plan or switch to other plans that may be available.

How much will it cost?

Participating carriers offer a product with rates that can vary based only upon a person's age, family type, place of residence, and premium payment mode. As of November 1, 2001, all carriers are also required to offer a rate for single parents with children.

You can call any of the insurers listed for specific information about the plans and the cost for you. The attachment lists the companies that are offering products and examples of what the monthly rates would be for certain types of persons. You may contact the Division of Insurance at 617-521-7777 for general information or call the company for information about the approved rate for your age, family type and place of residence.

Are there any other options if I can't afford health insurance?

Yes, there are other health programs that might assist you or your family, including:

MassHealth: a comprehensive health insurance program and premium assistance program for parents, children, senior citizens, and persons who are disabled or unemployed. Call **1-800-841-2900** for more information and an application.

Children's Medical Security Plan: a limited health insurance program for children providing only primary and preventive health care. Call **1-800-531-2229**.

Medical Security Plan: a subsidized health insurance plan for people who are receiving unemployment insurance benefits. Call **1-800-914-4455**.

In addition to the above, if you have a medical emergency and you do not have health insurance, you should ask the hospital for an application for "free care."

Whom should I call for additional information?

If you have general questions about the standard plans, allowable pricing practices, or the nongroup health insurance law, you can contact the Division of Insurance Consumer Section in Boston at (617) 521-7777 or in Springfield at (413) 785-5526, or access the list of available plans through the internet at www.state.ma.us/doi.

If you believe that your managed care plan has not complied with any statutory requirements, please contact the Bureau of Managed Care at 617-521-7372, send a fax to 617-521-7773 or send an e-mail to bmc.mailbox@state.ma.us.

If you have questions about your nongroup managed care plan or, if you have exhausted the internal appeal process within your nongroup managed care plan and want to apply for an external review, please contact the Office of Patient Protection at 1-800-436-7757, send a fax to 617-624-5046 or access information through the internet at www.state.ma.us/dph/opp.

Here are some of the questions you might want to ask a health insurance company when making your decision:

- How do I choose a doctor, and can I change doctors?
- Do I have to use specific doctors or hospitals? If so, is my doctor part of the plan's provider network?
- What happens if I don't use a doctor or hospital on the network list?
- What happens if my doctor leaves the plan's network?
- How do I obtain prescription medications?
- How does the company bill for premiums, and how do I want to pay? Do I have any options in how I pay my premiums (*e.g.*, monthly, quarterly or semiannually; by check or bank withdrawal)?
- Can I enroll directly with the company or does an intermediary or association have to process my paperwork? Are there any additional costs for enrolling through associations or intermediaries?
- If I pay in advance and later decide to cancel my coverage, am I entitled to a refund of any advance payment? How would the refund be calculated?
- Do I have to file claims? If so, how is it done?
- If I have to file a claim, how long does it take to process the paperwork?
- What is the procedure if I have a complaint?
- Is there a local office to help me with questions or problems?